Please complete, print and submit.

Reset Form

Annual Medical Benefits Verification/Other Insurance Information

Introduction

MMSI, a subsidiary of Mayo Foundation, processes and pays your medical claims. MMSI is required by law to verify eligibility and other insurance information for you and your enrolled dependents each year in order to file insurance claims on your behalf. To complete this process, please review steps 1-5, make any corrections, changes or additions, sign and date the form and return to MMSI in the enclosed return envelope.

Return form to:
MMSI
4001 41st Street NW
Rochester, Minnesota 55901-8901

Listed below is information that MMSI has on file regarding you and any enrolled family members. Please review and correct or complete any information that is inaccurate or not listed. If an eligible family member should be enrolled under your benefit plan but is not listed, please contact Human Resources.

STEP ONE
Family Members

Employee/Policyholder	Social Security Number	Date of Birth	Mayo Patient Number

Enrolled Dependents	Social Security Number	Date of Birth	Mayo Patient Number

STEP TWO
Other Insurance

Please Answer This Section

Are you or any of your enrolled dependents covered by another insurance plan (including Medicare) in addition to your Medical Plan? ☐ Yes ☐ No

If No:
- Sign the form in Step Five.
- Return the form to MMSI in the enclosed envelope.

If Yes:
- Complete all of the requested information on the other side of this form.
- Sign the form in Step Five.
- Return the form to MMSI in the enclosed envelope.

Important: Please complete the back side of this form.

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STEP THREE
Please Read

Listed below is information which MMSI has on file regarding your family's other health / dental insurance. **Please review and correct any information that is inaccurate.** If you have other health / dental insurance which is not listed below, please provide the information requested. If you need more space for additional insurance plans, please attach another sheet of paper.

STEP FOUR

It is important to complete all information requested

Shaded areas must be completed

Insurance Company Name | Street Address | City, State, Zip Code

ID or Policy No. | Group No. | Medicare No. (*include letter*)

Policyholder's Name | Policyholder's Employer | Policyholder's Social Security No.

Coverage Effective Date | Coverage Termination Date | ☐ Family ☐ Single Coverage

Type of Coverage: ☐ HMO ☐ Medical / Hospital ☐ Hospital Only ☐ Dental ☐ Other

List all family members covered by the above policy:

Insurance Company Name | Street Address | City, State, Zip Code

ID or Policy No. | Group No. | Medicare No. (*include letter*)

Policyholder's Name | Policyholder's Employer | Policyholder's Social Security No.

Coverage Effective Date | Coverage Termination Date | ☐ Family ☐ Single Coverage

Type of Coverage: ☐ HMO ☐ Medical / Hospital ☐ Hospital Only ☐ Dental ☐ Other

List all family members covered by the above policy:

STEP FIVE
Signatures and Authorizations

Important: Please Complete This Section

Your signature and the signatures of your spouse and any eligible dependents age 18 or older (if they will be enrolling in the plan) are important and **required**; without these, your provider may look to you for payment of services and you may have to file all your claims with us.

I authorize any physician, medical practitioner, hospital, clinic, medically related facility, insurance or reinsuring company, third party administrator, or other person having medical information about myself or my minor children to disclose such information to MMSI, other insurers/plans (including Centers for Medicare & Medicaid Services) and other healthcare providers as necessary for the provision or evaluation of services, the determination of claims or requests for services or benefits under my enrollment, or the administration of the plan. Such medical information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, alcohol and drug abuse, communicable diseases, diagnosis and treatment.

I authorize MMSI to re-release such medical information as necessary for the purpose of treatment, payment and/or healthcare operations. This authorization shall be valid for one year from the date shown below. I agree that a photographic copy of this authorization shall be valid as the original. I can request and receive a copy of this authorization from the plan at any time I am enrolled with this plan.

I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any plans issued based on this application. Furthermore, if any claims are paid because of any false statements or omissions on this application, then I may be required to reimburse the Plan for such claims.

I (we) certify that the information on this form is correct.

Employee Signature: _____ Signature Required _____ Date_____

Spouse Signature: _____ Signature Required _____ Date_____

Dependent Signature(s): (Required if enrolled dependent(s) are age 18 or over)

_____ Date_____ _____ Date_____ _____ Date_____

Print Reset Form